BHC Behavioral Health Commission

Commission meeting

November 12, 2025

Briefing

In this presentation

Local match of CSB state funding

BHC study options and recommendations

Jail diversion and EDCOT

Mental Health Virginia's Warm Line

BHC 2025 study
options and recommendations

Process

- Staff provide brief overview of options and recommendations from each 2025 study
- Members ask questions at any time but vote after overview from each study
- All options and recommendations for one study will be taken up in a block, unless a member requests pulling out one or more items
- Options and recommendations that receive a majority overall and from each body become official BHC recommendations
- Patron assignment for each BHC recommendation will be done after this meeting

2025 BHC staff studies included 18 legislative options and recommendations for consideration by BHC members

Report	Number of options / recommendations by type of legislative action required				
	Legislation	Budget amendment	Budget amendment or Section 1 bill	Other[2]	Total
Marcus Alert implementation	4	5	--	1	10
Crisis services and civil commitment	--	1[1]	2		3
STEP-VA monitoring	--	2	3		5
Total	4	8	5	1	18

[1]Option 1 from crisis services and civil commitment could be combined with Option 3 from Marcus Alert implementation into a single budget amendment for pilot programs in 911 call centers

[2]Recommendation to fix an erroneous Code reference was addressed administratively by staff of the Code Commission

Implementation and effectiveness of Marcus Alert

- **Recommendation 2:** Amend § 9.1-193 (H) to change the Code reference from "clause (iv) of subdivision B 2 of § 37.2-311.1", to "clause (vi) of subdivision B 2 of § 37.2-311.1."
- **Explanation:** Subsection H of § 9.1-193 contains a typo. The subsection directs localities to implement Marcus Alert Protocol 1 in accordance with the state plan, but it currently references "clause (iv) of subdivision B 2 of § 37.2-311.1"—which pertains to reviewing the prevalence of crisis situations—rather than clause (vi)—the clause that references the implementation of Protocol 1.
- **Status:** Implemented

Implementation and effectiveness of Marcus Alert

- **Recommendation 4:** Include $7.8 million in the 2026-2028 Appropriation Act to enable the 13 CSBs that have not yet implemented the Marcus Alert system to begin planning activities.
- **Explanation:** The 13 CSBs that have not yet implemented the Marcus Alert system must receive planning funds in FY27 or FY28 in order to meet the July 2028 statutory deadline for statewide Marcus Alert implementation. Most successful Marcus Alert sites received planning grants one year before launching their system.

Implementation and effectiveness of Marcus Alert

- **Recommendation 6:** Amend §37.2-311.1 to specify that DBHDS is responsible for convening the Marcus Alert Evaluation Task Force, and to require that the Task Force be convened at least quarterly to design and implement an evaluation process.
- **Explanation:** The state plan developed to operationalize the Marcus-David Peters Act charges a Task Force with ongoing monitoring and evaluation of the Marcus Alert system. However, the Task Force has never met, in part because no agency is responsible for making sure the Task Force is playing its intended role. To ensure the system's long-term success, the state must develop robust outcome measures and a process to evaluate performance on these measures.

Implementation and effectiveness of Marcus Alert

- **Recommendation 6:** Include $150,000 and one FTE in the 2026-2028 Appropriation Act for DBHDS to hire an analyst responsible for evaluating the Marcus Alert system's performance.
- **Explanation:** The Marcus Alert Evaluation Task Force requires ongoing data collection and analysis to measure system performance. A dedicated staff position within DBHDS will be required to support this work, because no existing position at the agency has either the expertise or the time to absorb these new responsibilities.

Implementation and effectiveness of Marcus Alert

- **Option 1:** Update language in the 2026-2028 Appropriation Act, Grants to Localities (790) to (i) remove the reference that each CSB implementing Marcus Alert receives a fixed allocation of $600K annually; (ii) grant DBHDS discretion to distribute available Marcus Alert funds based on the needs of each community; and (iii) stipulate that CSBs must direct a portion of funding received to PSAPs for necessary system updates, training, and related expenses.
- Explanation: Each CSB receives $600K per year for Marcus Alert regardless of size, needs, or fiscal situation. Equal funding across CSBs does not accommodate the variation that exists in implementation decisions (e.g., CSBs that choose not to create a co-response team may not need $600K).

Implementation and effectiveness of Marcus Alert

- **Option 2:** Amend § 15.2-1726 to include co-response teams with jurisdiction in multiple localities as an acceptable form of reciprocal agreement between law enforcement agencies.
- **Explanation:** Having one co-response team in every jurisdiction may be inefficient, especially for small law enforcement agencies and for small jurisdictions that may not have enough need on their own to justify a team. One solution to this is multi-jurisdictional co-response teams, which currently exist in a few localities. A barrier to creating more multi-jurisdictional co-response teams is that some law enforcement agencies are uncertain about the legality of multi-departmental co-response efforts. This option would clarify in statute that co-response is an acceptable form of inter-agency agreement between law enforcement agencies.

Implementation and effectiveness of Marcus Alert

- **Option 3**: Include language and funding in the 2026-2028 Appropriation Act for pilot programs that would enable regional mobile crisis response (MCR) teams to be dispatched from 911 call centers using different approaches.
- **Explanation:** A large portion of Virginia's behavioral health crisis calls go to 911 call centers, but they currently have no ability to dispatch behavioral health-only MCR teams. As a result, individuals in crisis frequently receive a response from law enforcement when they could have been better served by MCR. There are several methods for MCR to be integrated with 911; testing these methods in a limited pilot would yield efficacy data to inform future funding decisions.

Implementation and effectiveness of Marcus Alert

- **Option 4**: Include $125,000 and one FTE in the 2026-2028 Appropriation Act for DCJS to hire a Co-response Coordinator.
- **Explanation:** Co-response teams in Virginia vary widely in terms of their composition, hours, policies, and practices, and there is limited state guidance or oversight to ensure they maximize their potential for diverting individuals from the criminal justice system. Limited data exists on their effectiveness and the practices that yield better outcomes. Two-thirds of localities have not yet implemented Marcus Alert, so there will likely be many new co-response teams forming in the next two years. These teams, in addition to existing teams, may benefit from guidance, including information on best practices and on variations in co-response practices across the state.

Implementation and effectiveness of Marcus Alert

- **Option 5:** Amend § 9.1-193 to transfer responsibility from PSAPs to individuals for initiating the deletion of their profiles from Marcus Alert local databases when they reach the age of 18.
- **Explanation:** Statute requires PSAPs to delete a child's profile from the local Marcus Alert database when they turn 18. Many PSAPs rely on third-party platforms to develop a voluntary database of people with behavioral health needs, in accordance with statute. However, PSAPs have no power to delete an individual's profile from these external platforms: only the person who made the profile can delete the information. Some PSAPs are therefore concerned that they may be unintentionally out of compliance with the law.

Implementation and effectiveness of Marcus Alert

- **Option 6:** Amend §37.2-311.1 to specify that DBHDS and DCJS have the authority to update the "written plan for the development of a Marcus Alert system," provided that stakeholders are afforded an opportunity to provide input before updates are finalized.
- **Explanation:** The state plan for Marcus Alert was completed in 2021 and may need updates to reflect the evolving nature of the crisis system as well as best practices that have emerged. DBHDS and DCJS lack explicit authority to update the plan, which has led to uncertainty among agency staff. Giving these agencies the ability to make necessary updates would allow Marcus Alert to grow alongside the crisis system.

Aligning crisis services and the civil commitment process

- **Option 1:** Include language and funding in the 2026-2028 Appropriation Act for pilot programs that would enable regional mobile crisis response (MCR) teams to be dispatched from 911 call centers to individuals who are at high risk of coming under an ECO but who do not present an imminent public safety risk (Level 3), using various approaches.
- **Explanation:** Most individuals who meet Level 3 criteria call 911 during a crisis but only ~2% receive a response from behavioral health-only teams, the preferred response when there is no imminent risk to public safety. 911 call centers are not allowed to dispatch the 100+ MCR teams built as part of Virginia's crisis system expansion, and few exist outside of MCRs. A pilot project will help test out several methods for dispatching MCR teams from 911 to individuals who meet Level 3 criteria, before adopting a statewide solution.

Aligning crisis services and the civil commitment process

- **Option 2:** Include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing the HHR Secretary to identify the regulatory, billing, or training changes required to enable regional mobile crisis response teams to be dispatched based on calls from third parties (e.g., family members, concerned citizens).
- **Explanation:** Regional mobile crisis teams are rarely dispatched in response to calls from 3rd parties, which are disproportionately made on behalf of individuals who meet Level 3 criteria. These individuals therefore do not receive the in-person services they may need, and may deteriorate. It is unclear whether third-party dispatch is allowed based on the large volume of statutory, regulatory, and administrative requirements at the state and federal levels. However, some other states appear to dispatch mobile crisis response teams based on 3rd party referrals.

Aligning crisis services and the civil commitment process

- **Option 3:** Include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing DBHDS to identify strategies to serve more individuals subject to an ECO or TDO in crisis facilities by incentivizing existing CRCs and CSUs to follow a no-barrier approach and to offer a rapid drop-off option for law enforcement.
- **Explanation:** No-barrier facilities are an essential strategy to maximizing diversion from the civil commitment process for individuals who are experiencing an acute behavioral health crisis. A low proportion of individuals in Virginia CRCs (3%) and CSUs (11%) were under an ECO or TDO in FY25. Only one crisis facility in Virginia follows the no-barrier model and accepts all individuals, including involuntary and high acuity patients, while offering rapid drop-off to law enforcement officers.

STEP-VA performance monitoring and evaluation

- **Recommendation 1:** Update language in the 2026-2028 Appropriation Act to appropriate STEP-VA funding as one amount rather than by individual STEP.
- **Explanation:** DBHDS and CSBs currently lack flexibility to reallocate funds among STEPs because the Appropriation Act sets out funding for each STEP. Providing a single pool of funds would allow DBHDS and CSBs to direct resource where they are most needed. The STEP-specific funding structure was useful to accommodate the program's phased implementation, but it now limits the ability of the state and of CSBs to respond to changing community needs and to address capacity gaps.

STEP-VA performance monitoring and evaluation

- **Option 1:** Include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing the Secretary of HHR to convene a taskforce to develop a proposed strategic vision for STEP-VA.
- **Explanation:** Virginia statute does not provide a long-term vision for the program, only requiring that the nine core STEPs exist at every CSBs. This lack of direction has created confusion among stakeholders about what STEP-VA should accomplish, how success should be measured, and how to prioritize funding going forward. A clear legislative vision would help align objectives, improve strategic planning, and provide direction on expectations. The task force's proposed vision would be reported to the BHC for legislative input and would be revised to incorporate legislative and public input.

STEP-VA performance monitoring and evaluation

- **Option 3:** Include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing DBHDS and DMAS to assist a representative sample of CSBs with conducting an analysis of their Medicaid revenue.
- **Explanation:** Some CSBs have struggled to maximize Medicaid revenue due to the laborious and complex process for filing claims, duplicative training, credentialing delays, and high denial rates among others. Since FY17, Medicaid revenue per visit has increased by 17 percent, whereas the cost of a visit increased by 64% and other funding sources increased by 66%. Medicaid leverages federal matching dollars and therefore reduces reliance on state and local funds. An in-depth analysis would help identify specific obstacles that hinder CSBs from maximizing Medicaid revenue.

STEP-VA performance monitoring and evaluation

- **Option 4:** Include language in the 2026-2028 Appropriation Act or introduce a Section 1 bill directing DMAS to identify the specific steps necessary to transition to a prospective payment system (PPS) and its fiscal impact.
- **Explanation:** Virginia has been moving toward CCBHC requirements and quality standards without adopting the PPS financing mechanism designed to sustain the incremental costs of the model. Virginia has opted not to formally pursue CCBHC certification in 2017 and again in 2023 due to the expected fiscal impact of shifting to PPS. Understanding the steps, timeline, and up-to-date fiscal impact of transitioning to PPS would help inform decisions about the state's adoption of the CCBHC model.

STEP-VA performance monitoring and evaluation

- **Option 5:** Include language and $2 million in the first year of the 2026-2028 Appropriation Act for DBHDS to support a statewide and CSB-level comprehensive needs assessments for services included in STEP-VA.
- **Explanation:** Virginia lacks a robust assessment of need for STEP-VA services across the state. Without a baseline estimate of community need, it is impossible to determine whether STEP-VA is effectively reducing gaps in behavioral health care, whether current funding levels are adequate, or how to optimize allocation among STEPs and CSBs. The needs assessments would help identify system-level issues and barriers, determine the need for additional infrastructure and resources, and fulfill CCBHC certification requirements, if pursued.

Next steps

- Staff will reach out to members after the November meeting to identify patrons
  - Members can volunteer if interested in specific recommendations
  - Other recommendations may be assigned based on members' committee assignments and relevance to topic of recommendation
- Staff will draft budget amendments and work with DLS on bill drafting
  - Bills or placeholders will be prefiled by deadline
  - Patrons will review budget and bill language
- Draft bills and budget amendments will be available to Commission members at December meeting

Addressing policy issues pertaining to individuals with developmental disabilities

Topic

- During its October 2025 meeting, BHC members discussed the importance of researching and addressing issues affecting individuals with developmental disabilities, how these activities could best be conducted, and whether they should become a new responsibility of BHC members and staff

Definitions

Behavioral health disorders

Mental health conditions

- Depression
- Anxiety
- Serious mental illness
  - Schizophrenia
  - Bipolar disorder

Substance use disorders

- Alcohol
- Cannabis
- Opioids

Developmental disabilities

Intellectual disabilities

- Down syndrome
- Fragile X syndrome

Autism spectrum disorder

Other developmental disabilities

- Cerebral palsy
- Tourette syndrome
- ADHD

Size of population and potential impact

Behavioral health disorders[1]

- Mental health conditions — 23%
  - Serious mental illness: 6%
- Substance use disorders — 17%

Developmental disabilities[2]

- Intellectual disabilities — 2%
- Autism spectrum disorder — 3%
- Other developmental disabilities — 6%

[1]NSDUH State Estimates (2022-2023), Virginia population 12 and up; [2]CDC National Center for Health Statistics (2019-2021), children 3-17 nationwide

Conditions already examined by multiple state entities

	Commission	Description	Structure
MH SUD	**Behavioral Health Commission**	Studies, makes recommendations, and provides ongoing oversight to improve Virginia's behavioral health services and system.	▪ Legislative ▪ Research ▪ Full time staff
SUD	**Addiction and Recovery Council**	Recommends policies relevant to substance abuse to the Governor and the General Assembly and the Board of DBHDS, and coordinate programs and activities.	▪ Executive ▪ No research ▪ No full time staff
All DD	**Virginia Board for People with Disabilities**	Makes sure people with developmental disabilities (DD) and their families have what they need to live their best lives through policy advocacy, education, community outreach, and evaluation, etc.	▪ Executive branch ▪ Research ▪ Full time staff
ASD	**Autism Advisory Council**	Promotes coordination of services and resources among agencies involved in ASD services.	▪ Legislative branch ▪ No research ▪ No full time staff
All	**Virginia Disability Commission**	Identifies and recommends legislative priorities and policies to the General Assembly to support developing and reviewing services and funding for Virginians with physical and sensory disabilities.	▪ Legislative branch ▪ No research ▪ No full time staff

Resources and bandwidth needed for BHC to take on additional responsibilities would be costly and likely impact current work

- Expanding scope of BHC would require 2-3 additional analysts, 1 leadership position and/or research SME, and new office space & furnishings
- Estimated budget needed: $660K
  - 2 additional studies focused on DD / year
  - Monitoring of DD programs and services on rotating basis
- Anticipated impact on existing responsibilities and other considerations
  - Diminished attention placed on mental health at only entity focused on these policy issues
  - Expanding scope of current studies to would extend completion date or reduce depth
  - Learning curve on new topic for entire staff
  - Delayed results to allow for hiring staff – expected to take 12 months

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Next meeting

December 2, 2025

Visit bhc.virginia.gov for meeting materials